Establishing Consensus on a Screening Tool for the Neglected Sexual Side Effects after Prostate Cancer treatment: A Modified E-Delphi Study

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**The NSSE after PCa Screening Tool (additional Demographic Information)**

|  |  |
| --- | --- |
| **Who is completing this questionnaire?** | **Mark x** |
| You are completing this questionnaire by yourself |  |
| You are completing this questionnaire with your partner/spouse |  |
| You are completing this questionnaire on behalf of your partner, based on their experience. (*Please complete the information based on our partner.)* |  |

**About you:**

**How old are you:**

|  |  |
| --- | --- |
| **Race** | **Mark x** |
| *White* |  |
| Black |  |
| Coloured |  |
| Asian |  |
| Other (please specify) …………………………. |  |

|  |  |
| --- | --- |
| **Are you on medication to treat Hypertension?** | **Mark x** |
| Yes |  |
| No |  |
| Specify if YES (name and dose) | |

|  |  |
| --- | --- |
| **Are you on medication to treat Depression?** | **Mark x** |
| Yes |  |
| No |  |
| Specify if YES (name and dose) | |

|  |  |
| --- | --- |
| **Did you receive your prostate cancer management in the private or government sector?** | **Mark x** |
| Private sector |  |
| Government Sector |  |
| Both Private and Government Sector (Please elaborate) | |

|  |  |
| --- | --- |
| **What was the stage of the prostate cancer when you were initially diagnosed?** | **Mark x** |
| Stage 1 |  |
| Stage 2 |  |
| Other (Please specify) | |

|  |  |
| --- | --- |
| **Indicate the management you have received and indicate how long ago the treatment was done.** | **Mark x** |
| Robotic Prostatectomy |  |
| If so, how long ago did you finish your treatment | |
| Laparoscopic Prostatectomy |  |
| If so, how long ago did you finish your treatment | |
| Open prostatectomy |  |
| If so, how long ago did you finish your treatment | |
| Radiation (External Beam Radiation) |  |
| If so, how long ago did you finish your treatment | |
| Radiation (Brachytherapy) |  |
| If so, how long ago did you finish your treatment | |
| Other (please specify): |  |
| If so, how long ago did you finish your treatment | |

|  |  |
| --- | --- |
| **Are you currently sexually active?** | **Mark x** |
| Yes, with a partner |  |
| Yes, but without a partner |  |
| No, not at all |  |
| **Are you on medication to treat Erectile Dysfunction?** | **Mark x** |
| Yes |  |
| No |  |
| Specify if YES (name and dose) | |

|  |  |
| --- | --- |
| **What is your perceived effectiveness of the above mention drug/drugs (choose one)?** | **Mark x** |
| Not effective |  |
| Somewhat effective |  |
| Effective |  |
| Very effective |  |
| *Extremely effective* |  |

|  |  |
| --- | --- |
| **Are you currently using a vacuum erectile device?** | **Mark x** |
| Yes |  |
| No |  |

|  |  |
| --- | --- |
| **If yes, what is your perceived effectiveness of the vacuum erectile device?** | **Mark x** |
| Not effective |  |
| Somewhat effective |  |
| Effective |  |
| Very effective |  |
| *Extremely effective* |  |

|  |  |
| --- | --- |
| **Are you currently using a penile prosthesis?** | **Mark x** |
| Yes |  |
| No |  |

|  |  |
| --- | --- |
| **If yes, what is your perceived effectiveness of the penile prosthesis?** | **Mark x** |
| Not effective |  |
| Somewhat effective |  |
| Effective |  |
| Very effective |  |
| *Extremely effective* |  |

**The Neglected Sexual Side Effects After Prostate Cancer Screening Tool**

*Think about the last 3 months and compare this time to the time before your prostate cancer treatment, and then answer each of these questions.*

1. **Have you experienced any involuntary leaking of urine associated with sexual arousal (besides during an orgasm)?** \*Arousal can be defined as the state of being sexually excited with or without ejaculation, and with or without a partner.

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | **I am currently unable to experience any sexual arousal** |
| **If applicable, how problematic is this when you engage in sexual activity?**   |  |  | | --- | --- | | Never………………………………. | **0** | | Seldom……………………………. | **1** | | Sometimes………………………. | **2** | | Often………………………………. | **3** | | Always……………………………... | **4** | |  |  |

1. **Have you been able to achieve an orgasm? \***An orgasm may be achieved with or without ejaculating

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | **I am currently unable to achieve an orgasm** |
| **If applicable, how problematic is this when you engage in sexual activity?**   |  |  | | --- | --- | | Never………………………………. | **0** | | Seldom……………………………. | **1** | | Sometimes………………………. | **2** | | Often………………………………. | **3** | | Always……………………………... | **4** | |  |  |

1. **Have you experienced any involuntary leaking of urine during an orgasm? \***An orgasm may be achieved with or without ejaculating

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | **I am currently unable to achieve an orgasm** |
| **If applicable, how problematic is this when you engage in sexual activity?**   |  |  | | --- | --- | | Never………………………………. | **0** | | Seldom……………………………. | **1** | | Sometimes………………………. | **2** | | Often………………………………. | **3** | | Always……………………………... | **4** | |  |  |

1. **Have you experienced pain during an orgasm? \***An orgasm may be achieved with or without ejaculating

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | **I am currently unable to achieve an orgasm** |
| **If applicable, how problematic is this when you engage in sexual activity?**   |  |  | | --- | --- | | Never………………………………. | **0** | | Seldom……………………………. | **1** | | Sometimes………………………. | **2** | | Often………………………………. | **3** | | Always……………………………... | **4** | |  |  |

1. **When you ejaculate, has the volume of ejaculatory fluid decreased?**

|  |  |  |
| --- | --- | --- |
| **Yes** | **No** | **I have had a prostatectomy and do not ejaculate anymore** |
| **If applicable, how problematic is this when you engage in sexual activity?**   |  |  | | --- | --- | | Never………………………………. | **0** | | Seldom……………………………. | **1** | | Sometimes………………………. | **2** | | Often………………………………. | **3** | | Always……………………………... | **4** | |  |  |

1. **Have you experienced any sensory changes in your penis?**

|  |  |
| --- | --- |
| **Yes** | **No** |
| **If applicable, how problematic is this when you engage in sexual activity?**   |  |  | | --- | --- | | Never………………………………. | **0** | | Seldom……………………………. | **1** | | Sometimes………………………. | **2** | | Often………………………………. | **3** | | Always……………………………... | **4** | |  |

1. **Has your penis become shorter in length?**

|  |  |
| --- | --- |
| **Yes** | **No** |
| **If applicable, how problematic is this when you engage in sexual activity?**   |  |  | | --- | --- | | Never………………………………. | **0** | | Seldom……………………………. | **1** | | Sometimes………………………. | **2** | | Often………………………………. | **3** | | Always……………………………... | **4** | |  |

1. **Has your penis developed any new curvatures or bends?**

|  |  |
| --- | --- |
| **Yes** | **No** |
| **If applicable, how problematic is this when you engage in sexual activity?**   |  |  | | --- | --- | | Never………………………………. | **0** | | Seldom……………………………. | **1** | | Sometimes………………………. | **2** | | Often………………………………. | **3** | | Always……………………………... | **4** | |  |